



OA Managed Choice POS HDHP

Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder:	Aspen HR PEO, LLC
Policyholder number:	GP-0175126
Control number:	CN-0175126 CN-0175127 CN-0175128 CN-0175129
Schedule of Benefits:	2B Open Access Managed Choice High Deductible Health Plan \$2,800 100%
Group policy effective date:	September 1, 2021
Plan effective date:	September 1, 2021
Plan issue date:	September 1, 2022
Plan revision effective date:	September 1, 2022

Underwritten by Aetna Life Insurance Company in the state of California.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance** that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
 - “In-network coverage”, we mean you get care from a **network provider**.
 - “Out-of-network coverage”, we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles, copayments, and coinsurance**.
- **The coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
 - **Deductible**
 - **Maximum out-of-pocket limits**
 - Maximums

Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company’s group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

Plan features	Deductible/Maximums	
	In-network coverage*	Out-of-network coverage*
Deductible		
You have to meet your Calendar Year deductible before this plan pays for benefits.		
Individual	\$2,800 per Calendar Year	\$6,000 per Calendar Year
Family	\$5,600 per Calendar Year	\$12,000 per Calendar Year
Deductible waiver		
The Calendar Year deductible is waived for all of the following eligible health services :		
<ul style="list-style-type: none"> • Preventive care and wellness • Family planning services - female contraceptives 		
Deductible waiver provision for preventive prescription drugs		
Deductible waiver provision for preventive prescription drugs . No deductible will apply to preventive covered prescription drug expenses for those prescription drugs used to treat:		
The prevention of conditions relating to:		
<ul style="list-style-type: none"> • Hypertension • Heart disease • Diabetic complications • Asthmatic episodes • Conditions resulting from osteoporosis • Stroke • Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy. 		
Per admission copayment		
Per admission copayment	\$500 per admission	Not applicable
Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	\$5,500 per Calendar Year	\$12,000 per Calendar Year
Family	\$11,000 per Calendar Year	\$24,000 per Calendar Year

*See *How to read your schedule of benefit and important note* at the beginning of this schedule of benefits

Precertification penalty

This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section.

Failure to **precertify** your **eligible health services** when required will result in the following penalty:

- A \$400 penalty will be applied separately to each type of **eligible health services** (the penalty will never exceed the cost of the benefit)

Precertification and/or **step therapy** for certain **prescription drugs** may be required. In this case, the **prescription drug** will not be covered until you get prior authorization.

The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.

**See How to read your schedule of benefit and important note at the beginning of this schedule of benefits*

Eligible health services	In-network coverage*	Out-of-network coverage*
1. Preventive care and wellness		
Routine physical exams		
Performed at a physician's, PCP office	100% per visit No deductible applies	50% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per 12 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	1 visit
Preventive care immunizations		
Performed in a facility or at a physician's office	100% per visit No deductible applies	50% (of the recognized charge) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

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Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No deductible applies	50% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit
Preventive screening and counseling services		
Office visits <ul style="list-style-type: none"> • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer 	100% per visit No deductible applies	50% (of the recognized charge) per visit
Obesity and/or healthy diet counseling maximums:		
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs maximums:		
Maximum visits per 12 months	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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Use of tobacco products maximums:		
Maximum visits per 12 months	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No deductible applies	50% (of the recognized charge) per visit
Maximums	<p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.</p>	<p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card.</p>
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
<p>*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Prenatal care		
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only (includes participation in the California Prenatal Screening Program)	100% per visit No deductible applies	50% (of the recognized charge) per visit
Important note: You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	100% per visit No deductible applies	50% (of the recognized charge) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*
*Important note: Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits.		
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% per item No deductible applies	50% (of the recognized charge) per item
Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet-certificate for limitations on breast pump and supplies.		

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Family planning services – female contraceptives		
Female contraceptive education and counseling services office visit	100% per visit No deductible applies	50% (of the recognized charge) per visit
Devices		
Female contraceptive device provided, administered, or removed, by a physician during an office visit and follow up services	100% per item No deductible applies	50% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient	100% per admission No deductible applies	50% (of the recognized charge) per admission
Outpatient	100% per visit No deductible applies	50% (of the recognized charge) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
2. Physicians and other health professionals		
Physicians and specialists office visits (non-surgical)		
Physician services		
Office hours visits (non-surgical) non preventive care	\$30 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Telemedicine consultation by a physician, PCP	\$30 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Telemedicine consultation by a specialist	\$60 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit

Allergy injections		
Performed at a physician's or specialist office when you do not see the physician	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Immunizations when not part of the physical exam		
Immunizations when not part of the physical exam	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Specialist		
Specialist office visits		
Office hours visits (non-surgical)	\$60 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit

Physician surgical services		
Physicians and specialists office visits		
Performed at a physician's, PCP office	\$30 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Performed at a specialist's office	\$60 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit

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Walk-in clinic visits

Not all preventive care services are available at all **walk-in clinics**. The types of services offered will vary by the **provider** and location of the clinic. These services may also be obtained from a network **physician**.

Description	Network Benefit Level		Out-of-network benefit level
	Designated network coverage	Non-designated network coverage	Out-of-network coverage
Non-emergency services	100% (of the negotiated charge) per visit after deductible	\$30 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter after deductible	50% (of the recognized charge) per visit after deductible
Preventive care immunizations	100% (of the negotiated charge) per visit, no deductible applies	100% (of the negotiated charge) per visit, no deductible applies	50% (of the recognized charge) per visit after deductible
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Preventive screening and counseling services	100% (of the negotiated charge) per visit, no deductible applies	100% (of the negotiated charge) per visit, no deductible applies	50% (of the recognized charge) per visit after deductible
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB

Important Note:

Designated network provider

A **network provider** listed in the **directory** under *Best Results for your plan* as a **provider** for your plan.

Non-designated network provider

A **provider** listed in the **directory** under the *All other results* tab as a **provider** for your plan.

See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network walk-in clinic **provider**. Non-designated network walk-in clinic **providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
3. Hospital and other facility care		
Hospital care		
Inpatient hospital	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	\$300 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Home health care		
Outpatient	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per Calendar Year	<p>120</p> <p>Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals at least a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care</p> <p>The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge</p>	<p>120</p> <p>Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals at least a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care</p> <p>The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge</p>

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Hospice care		
Inpatient facility	100% (of the negotiated charge) per admission thereafter, after the per admission copayment	50% (of the recognized charge) per admission
Maximum days per lifetime	Unlimited	Unlimited
Hospice care		
Outpatient	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
	Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day
Outpatient private duty nursing		
Outpatient private duty nursing	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.
Skilled nursing facility		
Inpatient facility	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission
Maximum days per Calendar Year	60	60

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Eligible health services	In-network coverage*	Out-of-network coverage*
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room	\$350 then the plan pays 100% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
<p>Important Note:</p> <ul style="list-style-type: none"> As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share (deductible, copayment, and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill. A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. 		
Urgent care		
Urgent medical care (at a non- hospital free standing facility)	\$85 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Non-urgent use of urgent care provider (at a non- hospital free standing facility)	Not covered	Not covered
A separate urgent care deductible or copayment/coinsurance will apply for each visit to an urgent care provider .		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
5. Specific conditions		
Behavioral health		
Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient residential treatment facility Inpatient mental health treatment	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a physician or behavioral health provider (includes telemedicine consultation)	\$60 then the plan pays 100% (of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
All other outpatient mental health treatment as described in your [booklet-certificate] (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Substance related disorders treatment - inpatient		
Inpatient substance abuse detoxification	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission
Inpatient substance abuse rehabilitation		
Inpatient residential treatment facility		
Substance related disorders treatment - outpatient		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultation)	\$60 then the plan pays 100% (of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
All other outpatient substance abuse services (as described in your booklet-certificate)	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Partial hospitalization treatment		
Intensive outpatient program		
Birthing center and physician services		
Inpatient	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Family planning services - other		
Voluntary sterilization for males		
Outpatient	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Termination of pregnancy		
Inpatient	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Jaw joint disorder treatment		
Jaw joint disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maternity and related newborn care		
Inpatient	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission
Delivery services and postpartum care services		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Pregnancy complications		
Inpatient	100% (of the negotiated charge) per admission, after the per admission copayment	50% (of the recognized charge) per admission

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Gender reassignment counseling, surgery and injectable hormone replacement therapy			
Gender reassignment counseling	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Gender reassignment surgery	\$500 plus 100% (of the balance of the negotiated charge) per admission	50% (of the recognized charge) per admission	
Gender reassignment injectable hormone therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
Reconstructive surgery and supplies			
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*
Transplant services facility and non-facility			
Inpatient hospital transplant services	100% (of the negotiated charge) per transplant, after the per admission copayment	50% (of the negotiated charge) per transplant	50% (of the recognized charge) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Eligible health services	In-network coverage*		Out-of-network coverage*
Treatment of infertility			
Basic infertility			
Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	

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Eligible health services	In-network coverage*	Out-of-network coverage*
6. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Diagnostic lab work		
	100% (of the negotiated charge) per visit.	50% (of the recognized charge) per visit.
Diagnostic radiological services		
	100% (of the negotiated charge) per visit.	50% (of the recognized charge) per visit.
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy		
Performed in a physician's office	\$60 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Performed in a person's home	\$60 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Performed in the outpatient department of a hospital	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Performed at an outpatient facility other than the outpatient department of a hospital	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient radiation therapy		
Radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation		
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term rehabilitation services		
Outpatient Physical and Occupational Therapies		
	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient Speech Therapy		
	100% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Spinal manipulation		
Spinal manipulation	\$60 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Habilitation therapy services		
Outpatient physical and occupational therapies		
	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient speech therapy		
	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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Eligible health services	In-network coverage*	Out-of-network coverage*
7. Other services		
Acupuncture		
Acupuncture	\$30 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	50% (of the recognized charge) per visit
Maximum visits per Calendar Year	10	10
Ambulance service		
Ground, air or water ambulance	100% (of the negotiated charge) per trip	100% (of the recognized charge) per trip
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
DME	50% (of the negotiated charge) per item	50% (of the recognized charge) per item
Non-preventive hearing exams		
For adults and children	100% (of the negotiated charge) per visit No deductible applies.	50% (of the recognized charge) per visit
Nutritional supplements		
Nutritional supplements	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Osteoporosis		
Physician's office visits	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefit* at the beginning of this schedule of benefits

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Prosthetic and orthotic devices		
Prosthetic and orthotic devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Vision care		
Routine vision exams (including refraction)		
Performed by a licensed ophthalmologist or optometrist	100% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit
Maximum visits per 12 consecutive month period	1 visit	1 visit
All other outpatient services for which cost sharing is not shown above		
All other outpatient services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefit* at the beginning of this schedule of benefits
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AL COCAmend-2021 01

Eligible health services	In-network coverage*	Out-of-network coverage*
8. Outpatient prescription drugs		
Plan features	Deductible/Copayment/Coinsurance/Maximums	
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs		
The Calendar Year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a network pharmacy . This means that such risk reducing breast cancer prescription drugs will be paid at 100%.		
Deductible and copayment/coinsurance waiver for contraceptives		
The Calendar Year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at a network pharmacy . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug for that method paid at 100%. We will cover brand-name emergency contraceptive “Ella” until such time as a generic equivalent is approved by the FDA. At that time, only a generic equivalent will be covered. 		
The Calendar Year deductible and the per prescription copayment/coinsurance continue to apply to prescription drugs that have a generic equivalent or generic alternative available within the same therapeutic drug class obtained at a network pharmacy unless you are granted a medical exception.		
Deductible waiver for preventive prescription drugs		
No deductible will apply to preventive covered prescription drug expenses for those prescription drugs used for:		
The prevention of conditions relating to:		
<ul style="list-style-type: none"> • Hypertension • Heart disease • Diabetic complications • Asthmatic episodes • Conditions resulting from osteoporosis • Stroke • Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy 		

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Partial fill dispensing for Schedule II controlled substances, such as opioids

Partial fill dispensing allows less than the entire prescription to be filled at a **pharmacy**. You will pay a prorated amount of your cost share based on the size of the supply.

Important note:

- Review the How to access out-of-network pharmacies section of the booklet-certificate for more information on how these pharmacies are subject to higher out-of-pocket costs.

Preferred generic prescription drugs

Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a retail pharmacy	\$10 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$20 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered

Value prescription drugs

Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a retail pharmacy	\$3 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$6 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered

Non-preferred generic prescription drugs

Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a retail pharmacy	\$70 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$140 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered

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Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	\$45 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$90 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	\$70 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$140 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	\$0 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$0 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered
Specialty drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	Copayment is 30% (of the negotiated charge) but will be no more than \$250 per supply Coinsurance is 100% (of the negotiated charge)	Not Covered

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy	100% per prescription or refill	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.

**See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Family planning services - female contraceptives

If your **provider** recommends a particular service or FDA-approved item based on a determination of **medical necessity**, that service or item will be covered without cost sharing, regardless of whether it is generic or brand-name. We will defer to the determination made by your **provider**. **Medical necessity** may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by your **provider**.

<p>Female contraceptives that are generic prescription drugs:</p> <ul style="list-style-type: none"> • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches 	<p>\$0 per prescription or refill</p> <p>No deductible applies</p>	<p>Paid according to the type of drug per the schedule of benefits, above</p>
<p>Female contraceptives that are brand-name prescription drugs:</p> <ul style="list-style-type: none"> • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches 	<p>Paid according to the type of drug per the schedule of benefits, above</p>	<p>Paid according to the type of drug per the schedule of benefits, above</p>

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy	\$0 per prescription or refill No deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card. Coverage for tobacco cessation prescription drugs is not subject to any precertification requirements.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card. Coverage for tobacco cessation prescription drugs is not subject to any precertification requirements.

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** is available, you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

that are listed in the first part of this schedule of benefits.

Deductible provisions
Eligible health services that are subject to the deductible include prescription drug eligible health services provided under the medical plan prescription drug plan.
Eligible health services applied to the out-of-network deductibles will not be applied to satisfy the in-network deductibles . Eligible health services applied to the in-network deductibles will not be applied to satisfy the out-of-network deductibles .
The deductible may not apply to certain eligible health services . You must pay any applicable copayments/coinsurance for eligible health services to which the deductible does not apply.
Individual This is the amount you owe for in-network and out-of-network eligible health services each Calendar Year before the plan begins to pay for eligible health services . This Calendar Year deductible applies separately to you and each of your covered dependents. After the amount you pay for eligible health services reaches the Calendar Year deductible , this plan will begin to pay for eligible health services for the rest of the Calendar Year.
Family This is the amount you and your covered dependents owe for in-network and out-of-network eligible health services each Calendar Year before the plan begins to pay for eligible health services . After the amount you and your covered dependents pay for eligible health services reach this family Calendar Year deductible , this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the Calendar Year.
To satisfy this family deductible limit for the rest of the Calendar Year, the following must happen: <ul style="list-style-type: none">▪ The combined eligible health services that you and each of your covered dependents incur towards the individual Calendar Year deductibles must reach this family deductible limit in a Calendar Year.
When this occurs in a Calendar Year, the individual Calendar Year deductibles for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit

Deductible credit

If you paid part or all of your **deductible** under prior coverage for the Calendar Year that this certificate went into effect, the **deductible** of this plan for that Calendar Year will be reduced by the amount you paid under your prior coverage.

Upon request, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the prior coverage in order to receive the credit.

Copayments

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

Per Admission Copayment

A per admission **copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

The per admission **copayment** amount is equal to a facility's **semi-private room rate** for one day. However, for the **stay** of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the **hospital's actual room and board** charge on the first day of the **stay**.

Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will not be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will not be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/coinsurance** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an **urgent care provider**

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit

Maximum provisions
Eligible health services applied to the out-of-network maximum will be applied to satisfy the network maximum and eligible health services applied to the network maximum will be applied to satisfy the out-of-network maximum.
Calculations; determination of recognized charge; determination of benefits provisions
Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.
Outpatient prescription drug maximum out-of-pocket limits provisions
Eligible health services that are subject to the maximum out-of-pocket limit include eligible health services provided under the medical plan and the outpatient prescription drug plan.

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit